Adjustments to Managed Health Care: Pushing Against It, Going With It, and Making the Best of It

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Health care reform (Kongstvedt, 1997; Ziegler, 1998) of the 1990s was initiated to stem the escalation of U.S. health care costs that were projected to reach 18% of the gross domestic product by the year 2000 (Finkle, 1996). The health care marketplace was systematically restructured and “managed” to integrate finance with delivery of “health care that transfers financial risk associated with utilization and clinical outcomes from payers to insurers and providers” (Ziegler, 1998, p. xiv). Fragmented, fee-for-service, provider-dominated health care was replaced by a system of comprehensive services, capitation reimbursements, and payer-dominated health care. Similarly, hospital-based care rendered by subspecialty physicians that focused on medical care was reduced in favor of ambulatory service provided by nonspecialist physicians toward the ideal of health maintenance and prevention. Accountability measures entailed quality assurance and utilization review. Financial incentives rewarded members who used designated providers and providers who rendered cost-efficient services (American Occupational Therapy Association [AOTA], 1996). Nearly every aspect of health care in the United States, including occupational therapy (Abreu, 1996; AOTA, 1998; Crist, 1997), has been affected by health care reform.

Abreu (1996) identified four major issues that confront occupational therapists and other health care providers in managed care: financial gain versus humanistic care; service delivery to persons with chronic conditions, limited financial resources, or both; outcomes research; and professional role and practice changes. To address role and practice changes in managed care environments, other writers have suggested that occupational therapists align traditional occupational therapy values with managed care.
February 1999: I questioned myself: ‘‘What’s my role in the future of occupational therapy? ’’

... I believed that these outstanding graduates would have distinguished themselves as being recipients of leadership and academic awards in school and have become established business developers or facility administrators in their work environment.

... I selected these persons because they had the graduating classes of 1971 to 1996 (University of Florida, 1997). I sought to determine therapists’ perceptions of how their practice had changed as a result of managed health care. To achieve this goal, I conducted in-person, individual, focused interviews mailed instructions, I asked the participants to prepare therapis to function optimally in today’s and tomorrow’s reformed health care system.

... There are limited studies that address how occupational therapists are experiencing the health care revolution (Brayman, 1996; Pontozer, 1994). However, similar to Brayman’s (1996) suggestion that therapists consider their own “occupational adaptation” (Schkade & Shultz, 1992) in adjusting to health care reform, we might also consider occupational form and occupational performance (Baum & Law, 1997; Kielhofner & Barrett, 1998; Nelson, 1997), identity (Christiansen, 1999), purpose (Fisher, 1998), and competence (Hinojosa & Blount, 1998) in conceptualizing what it is like for therapists to adjust to radical change in their work environment.

... In this qualitative study, I sought to determine therapists’ perceptions of how their practice had changed as a result of managed health care. A second objective of this study was to seek therapists’ opinions about what we should be teaching students to prepare them for managed health care environments.

Method

Participants

I interviewed the participants for 1 to 3 hours at their convenience in their workplace or home. Interviews were audiotaped for transcription, and field observation notes were made during and after the interview. The journey by car to the participants’ locations afforded me an element of familiarity with the physical, natural, and, to some extent, regional and cultural contextual features of their environments as well as gave me time to reflect on interview conversations.

Before the interviews, the interview questions were mailed to the participants, and they were asked to reflect on their occupational therapy practices. Although specific probes had been formulated to prompt the participants, these were not necessary because the participants were ready to express their perceptions and experiences. On the preinterview mailed instructions, I asked the participants to prepare to discuss their experiences related to the following:

1. How has managed care affected your occupational therapy practice, and what do you do differently now in your practice versus what you did a few years ago?
2. What skills, attitudes, and knowledge do you use or need to function in managed health care?
3. How did you acquire these skills? Are these just a natural part of your own style and characteristics, or did you acquire these through reading, workshops, role models, and so forth?
4. What are the five most important things that occupational therapy educators need to be teaching students so that they can function in today’s and tomorrow’s managed health care?
Data Analysis

Verbatim transcripts of interview audiotapes were examined with reference to field notes (DePoy & Gitlin, 1994; Lincoln & Guba, 1985), following steps of data-driven inductive analyses suggested for a study that is not driven by theory or prior research (Boyantzis, 1998; Patton, 1980). The steps in this process were (a) reduction of raw information to categories regarding the four major questions of the study and unexpected topics within each transcript, (b) identification and labeling of recurring themes within and then across transcripts, (c) receipt of peer feedback regarding the categories and themes, and (d) interpretation of the results. One peer confirmed the definitions of my category labels (Gliner, 1994; Krefting, 1991; Patton, 1980) by identifying selected text passages as reflective of a change in practice, educational outcome, ethics, or other and then by applying secondary categories to these general categories. For example, for passages identified as being reflective of a change in practice, the individual passages were further categorized as assessment, intervention, goals, critical paths, practice theory, documentation, equipment, occupational therapy assistants, families, or other. After discussion with peers regarding what this multitude of changes meant to the participants, I was able to formulate overriding themes related to meaning that went beyond categorizations of participants’ transcripts. In addition, I received peer review in the form of informal discussions with other non-study therapists who affirmed that they had experiences in managed care similar to the trends that were emerging from my analysis.

Results

From a manifest content analysis (Boyantzis, 1998) of what the participants said in response to the first two interview questions (i.e., changes in their practice as a result of managed health care and the skills, attitudes, and knowledge relevant for practice in managed care), I generated two major categories of change: (a) the impact of reduced therapy times on therapy processes, and (b) the impact of the involvement of therapists in authorization for therapy. Participants reported that in response to reduced therapy times, assessments, outcomes, and goals were functional; documentation was increased; and family caregivers and occupational therapy assistants shouldered more responsibility for carrying out therapy aims. Participants reported that they now saw authorization for referrals to and payments for occupational therapy services as a crucial though time-consuming part of their role in managed care, whereas in the past, they were neither concerned about nor involved in these activities.

Responses to the third interview question (i.e., how therapists acquired these new abilities) did not yield sufficient or noteworthy data for analysis beyond categories of experience, reading, attending workshops, and advanced degrees. According to participants’ responses to the last interview question (i.e., what we should be teaching occupational therapy students), participants stated that graduates need to exit occupational therapy educational programs with a sound sense of their professional role, an ability to explain this role in many contexts, and knowledge of the finances of occupational therapy service delivery. In addition to responding to the four interview questions, participants unexpectedly described what they identified, or what I interpreted as, issues of ethics or professional compromise related to reformed health care that centered on overreferral and underreferral, financial goals versus therapy goals, and strategies to manipulate billing.

Interpretation and Discussion

In the conduct of this study, I was repeatedly struck by participants’ revelations of what it meant for them to experience a radical shift in their professional practice, even though I did not ask interview questions in the recommended format for phenomenological inquiry (Hasselkus, 1995). Beyond my categorizations of the participants’ descriptions of occupational therapy practice in reformed health care and their suggestions for occupational therapy education, I analyzed with some researcher subjectivity (Frank, 1997; Hasselkus, 1997; Patton, 1980) certain “latent underlying aspects or phenomena” (Boyantzis, 1998, p. 16) implicit in these 25 therapists’ voices; I listened to them speak from their professional hearts and souls of what it was like for them to practice in a changed health care environment. In general, I interpreted responses as being representative of three “ways of being” in managed care: “pushing against it,” that is, experiencing a personal–professional struggle to adjust to changes encountered at every moment of the practice day; “going with it,” that is, engaging a businesslike perspective that focused on the inevitability and practicality of changes necessary to accomplish fiscal accountability; and a “making the best of it,” that is, embracing an optimistic outlook on the positive opportunities that were embedded in change. These views do not represent participant groupings but rather groupings of responses into these broad perspectives, with each participant expressing one or more of the three perspectives in an interview.

Pushing Against It: The Personal–Professional Struggle

The participants expressed personal misgivings about the direction of health care and professional resistance to making the required changes. In contrast to the businesslike and optimistic features of the other two themes, the “pushing against it” theme reflected the feelings and emotions that were “stirred up” by the widespread, pervasive, rapid-paced changes that affected participants on personal and professional levels. Disagreeing with the direction of health care and being reluctant to comply with the “new order,”
participants expressed grief, frustration, fear, anger, and helplessness. They said that to align with new ways of doing things, they had to give up tried-and-true practice patterns, lay aside some of their expertise, submit to regulations they might not agree with, relinquish the autonomy and professional accomplishment they once knew, and learn new ways of being an occupational therapist. Many seemed relieved to have me sit and listen to their feelings, and all seemed eager to share their opinions and experiences. Although each participant appeared to believe that they were very successful in making the transition to managed health care, many expressed emotions reflective of individual as well as professional angst.

One distinguishing feature of their professional struggles was the perceived implication that in the new system they no longer knew “best” and that their professional opinion and experience were not honored in a system of reimbursement that seemed remote from therapy goals. The participants recognized with some outrage that case managers or insurance workers now make reimbursement and referral decisions that are based on criteria developed by payers motivated by cost-containment. One expressed a sense of powerlessness regarding limited therapy sessions: “I think it becomes draining on you and frustrating to know it doesn’t matter how good a therapist you are or how much time you put in with a patient. When they [the payer] say they have to go, they have to go.” Although the participants could see the necessity for assigning the conduct of therapy to parents, family members, caregivers, occupational therapy assistants, therapy aides, or other health care personnel, they expressed frustration about their loss of control over the occupational therapy process.

Participants reported that although they are skilled in an array of assessment procedures, they now use an abbreviated assessment repertoire of what they might have used in the past or would like to use with patients. They pointed out practical assessment strategies to offset the changes: increased use of information from family members and others, some occupational therapy assessments now being used by other professions, and occupational therapists doing only a portion of team assessments. Similarly, participants related how they have had to let go of some types of therapy expertise and practice in order to meet productivity imperatives and their treatment goals before the funding is depleted. One participant who works in an acute care hospital said:

"We don’t have the luxury to spend, in my opinion, two sessions on a perceptual and cognitive formal assessment…and six different areas of sensation, and measuring their range of motion down to the ‘nth’ degree…when you have a person for one half an hour and you still have to teach them to put their shoes on, and transfer on the toilet, and everything else, you can’t sit them on the mat necessarily for 45 minutes facilitating arm movements…You can’t spend a week trying to get them to weight shift, so that’s a frustration."

Central to participants’ feelings about themselves and their professional roles were the worry, frustration, and sadness expressed that “the patient[s are] not getting what they need” because of managed care constraints on therapy. One participant noted:

“I remember distinctly the case. It was a 7-year-old kid who could not make a fist after 6 weeks of therapy. So he was going to be like that for the rest of his life because they [the payer] said, “Well, that’s it.” I said, “You don’t understand; he can’t make a fist.” They [said], “We’re sorry, ma’am; he’s exceeded his limit.” The family couldn’t afford therapy.

Participants also expressed concern about patients going through the health care system “quicker and sicker” and rehabilitation being introduced too early in the patient’s recovery, such as dressing and bowel and bladder training before the patient with a spinal cord injury was physiologically stable. In an opposite scenario, patients with hand injuries had to wait for therapy authorization past the point when maximum therapy gains were possible.

The participants seemed aggravated about diverting time away from patient care to complete the excessive documentation required for reimbursement in managed health care. For example, one participant who is a supervisor noted that the therapists in her service provide actual patient care only 55% of the time, and a participant working in a home health care agency quipped, “You keep thinking somebody up there will realize that you are spending so much time doing paperwork—that you could be doing patient care—but nobody is going to get that smart, obviously.” Participants expressed some longing for the past when they had the autonomy to select and distribute adaptive equipment from clinic storehouses instead of fighting for funding and encountering delays for each device or piece of equipment.

Participants believed that new rules were not always clear. For example, a participant working in a nursing home commented about one outcome measurement (Uniform Data System for Medical Rehabilitation, 1993) as follows:

“There are about 12 or 15 sections of the Functional Independence Measure (FIM) that are scored, and probably about 10 of them are OT [occupational therapy] areas. Again, they [the payer] are telling you one message, how OT is so important to the function of the patient when they go home (by the FIM scores), but OTs aren’t allowed to see the patients as much. It’s very frustrating. Or, you come in after PT [physical therapy], like you are second.

Another participant expressed frustration about having to follow critical pathways strictly, summarizing her perceptions of the reformed health care restrictions on individualization of treatment as follows:

“It totally takes the art out of therapy.…You have to explain to them [the payer] that the person is not out of the splint because we take him out of the splint, he’s going to rupture. They are looking at this protocol that says at 6 weeks they come out of the splint. So, another patient, we might have out of the splint at 3 weeks.…That’s the art, and that’s the experience of being a therapist."

Getting on With It: The Businesslike Perspective

Some participants seemed to be saying to occupational
therapists in general, “Just get on with the business of health care!” From the businesslike perspective of these participants, corporate health care is a relentless new reality, and occupational therapy needs to be flexible and adaptable to remain competitive in the health care marketplace. Conscientiously responding to funding requirements and insurer priorities makes good business sense because this allows occupational therapists to be paid for their services.

This businesslike perspective addressed the issue of “what OT needs to do to ‘make it’ in reformed health care.” One participant said, “To remain competitive, occupational therapists must develop a mind-set of doing what is necessary to get paid.” Just as other health care professions are being held fiscally accountable for their productivity, participants said that occupational therapy must also document its efficiency and effectiveness. Businesslike participants noted how health care corporations can socialize the adaptable therapist into corporate rehabilitation by providing explicit productivity guidelines and linking the therapist’s marketability with product lines and customers to productivity. Participants believed that preferred practice patterns for managed health care include efficiently focusing on what occupational therapy can best achieve with the patient. They also believed that therapists need to be able to document services effectively; communicate successfully among therapy venues as the patient progresses through levels of care; cross-train other staff members to provide occupational therapy in a variety of settings with several types of patients; and remain open to peer review, outcomes assessment, and consumer reports. In short, these participants seemed to be saying that managed health care offers opportunities for occupational therapists to benefit from lessons from the business world:

You have to have a new idea of the way you are treating and a new perspective, and you have to have very much of a business mind. The good therapist can treat two or three patients at the same time...has no problem delegating to somebody, [and] has eyes in the back of her head where she can be watching the treatment of three people at one time, not just sitting there one-to-one. She writes her notes during her time with the patient and is very organized; is very confident in talking to the doctor, getting on the phone, doing two or three things at the same time; and is...prepared. She doesn’t come in and say, “Let’s see what we are going to do today.” but has actually planned out in her head, either in the morning or the night before, exactly what she is going to be doing with all of her people.

Making the Best of It: The Optimistic Outlook

Whether they seemed to be resisting or embracing reformed health care, each participant seemed to see opportunities for professional growth and expressed optimism, cautious or robust, about the future of occupational therapy in health care. They seemed motivated to make the best out of the reduced number of allowable treatment sessions, to be more accountable and focused about how they spend their time, and to be more systematic in the therapy process. As one participant stated about practice in general, “These were his problems. This is what I am doing. This is where we are seeing improvement. This is where we need to go....So, it’s constantly making you think about what you are doing, why, what you are looking for.”

Even if they resisted reformed health care, the participants seemed to have aligned their therapy processes with the demands of the managed care environment. They reported that occupational therapy was a practice moving in new directions, including sharpened assessment skills for targeted problems; measurable, functional goals that can be achieved in the treatment session; intervention in the context of the family; use of critical pathways to direct treatment and predict how long, on average, a certain type of patient takes to learn a given skill; and documentation of therapy efficacy and patient satisfaction. One participant said the following about managed health care:

I think it’s good in a way, though....I think it makes us more accountable, it makes us more aware of what we are doing. It makes us go back and reassess more often. Are we really doing what we set out to do? Are we working on the goals we really set up, or are we just going in there and doing OT and hoping that some of these things improve? I think it comes to the point where we have to do that now.

Shifting from hands-on care to consultation and teaching roles, participants provide consultation and supervise occupational therapy assistants and therapy aides. They instruct family caregivers, patients, and other health care personnel to carry out therapy programs and educate payers about occupational therapy services. One participant described how she gradually convinced a psychiatrist to refer to occupational therapy:

In the beginning, this managed care chief of psychiatry did not want OT because it’s an extra service in psychiatry, it’s billed on top of the daily rate, so he was very worried that he was going to lose his contracts with the companies if he did a lot of referrals for OT. But after working with him for the 14 months, he was begging me to stay. He said, “I see what a difference OT makes....Now I see that it’s really a part of getting them skilled before they leave.”

Participants described “occupational therapy that the patient can take home,” pointing to their expanded occupational therapy roles in homes and nonhospital settings when patients were released after a short hospital stay. Treatment in these situations was focused on the actual occupations in the person’s home versus skill building for those occupations. For example, one therapist noted:

I used to even do conies and pegs in the homes. I don’t do that anymore. I have them go into the kitchen and sort their silverware, or reach up and get things out of the cabinets, or open and close the refrigerator. Walk them through things. Do things with them that they are going to have to do.

Participants seemed to be saying that managed health care offered opportunities to “set the record straight about OT,” providing an opening to respond to payer demands to explain, define, and defend what we do and to identify functional gains from therapy. The participants believed that they could draw from their generalist strengths, flexibility, and problem-solving abilities to address patient
problems within the managed health care system. A participant working in a rural hospital marketed occupational therapy as a desired service because of its holistic approach that can meet several patient needs, noting, “The trick is to set priorities within the holistic approach.” Participants said that as treatment becomes more customer-driven and efficient, they would need to address individual needs and not “treat all persons with CVA [cerebrovascular accident] the same way”:

I think every environment is going to treat all ages and all diagnoses. I think at some point, the industry will require a facility to treat whatever and whomever they need to treat, whether it be a pediatric patient or whatever. So, that may go along with being a generalist. And being able to realize that what you do with a geriatric patient from a splintering perspective perhaps is just exactly what you do with a pediatric patient; it’s just a smaller person.

Educational Outcomes

On the basis of participants’ advice about how to educate occupational therapists for managed care environments, a profile of recommended new graduates’ abilities was derived in five areas. First, for service delivery that responds to limited treatment sessions in managed care, the new graduate must be able to adjust the pace and content of occupational therapy services and to prioritize, work quickly and efficiently, and provide focused and efficient evaluation and intervention across a wide variety of ages and disorders. Graduates should also be prepared to work with families and health care teams and to supervise therapy assistants.

Second, in their professional roles, new graduates must be able to respond to funding limitations by clearly delineating the role and value of occupational therapy services. Graduates must exude confidence in the role of an occupational therapist and be able to explain occupational therapy to others. Involvement in political advocacy and professional organizations as well as experience in examining ethical issues in practice are important for today’s graduates.

Third, business and finance acumen is important to be able to respond to cost-effective requirements for occupational therapy. Knowledge of the business world with its business language, such as “product lines” and “customers”; an understanding of budgets and reimbursement procedures; and a good grasp of the role of documentation in reimbursement are needed.

Fourth, communication skills are required to effectively respond to payers, referral sources, and others and to communicate the purpose, rationale, and outcomes of occupational therapy. The new graduate needs sharpened written and verbal communication skills to document patient goals, notes, and reports; to develop reviews and proposals for services; and to explain occupational therapy to the patient, family members, referral sources, and public. Negotiation and marketing skills are also important communication abilities.

Fifth, in response to role changes, the new graduate will need professional competencies in specific skills, such as splintering and modalities, yet be able to maintain a holistic perspective and be able to apply psychosocial skills to serve a wide range of patient problems. Now and in the future, technology expertise is necessary for the information age, and bilingual language skills are important because diversity in patient demographics continues to increase.

Ethical Issues

Ethical dilemmas arose when the personal and professional press to provide the best therapy for the patient conflicted with tailoring therapy to reimbursement guidelines (Burke & Cassidy, 1991; Hagen, 1999; Howard, 1991; Russell & Kanny, 1998). In those instances, participants described their struggles to distinguish between resourcefulness in manipulating therapy activities within reimbursement rules and compromise of professional values to conform to monetary values. Several participants discussed billing occupational therapy under physical therapy and inappropriate use of therapy aides. The issue of overreferral to occupational therapy primarily for monetary gain was contrasted with the underresponse of occupational therapists to the “difficult patient.” One participant revealed her concerns about therapists’ responses to the insidious pressure of productivity measures:

It’s not a huge thing, and it’s not things that clinicians probably do consciously. They are like, “Well, you know, I was probably with them a little over an hour. I will charge them five instead of four units.” All of a sudden that starts to happen with every single patient, and all of a sudden that gets you beyond your quota. That’s not humanly possible. So, you have to be making up the numbers somewhere. When they [facility administration] see the numbers, they see the dollar signs; they see the dollar signs, they can hire another therapist, and that means relief for you, so you are willing to do it. I think it’s not necessarily a conscious thing, but there is...a ton of ethical things going on.

The use of group treatment solely for the purpose of reimbursement raised the issue of efficiency versus patient access to the therapist. For example, for patients scheduled in a group, one participant believed that it was not right to charge for the time that the individual patient was waiting for his or her turn with the therapist: “There is a point past efficient, when you are not efficient anymore, if you are trying to see too many people at once. It’s rude to make that person wait there and watch other people exercise.” Another participant challenged therapists to consider whether they would be willing to pay out of pocket for what we are providing in a group: “This is a little gauge to ask yourself. If you set a person up on a peg board because you are too busy, or whatever the cause may be, would you be willing to pay for that?”

Conclusions

The 1990s have seen a radical restructuring of the U.S.
health care system to contain costs and provide quality services at the lowest price. Specialty care has given way to generalist care, and hospital care has shifted to ambulatory care. Findings in this study suggest that the reduced amount of time in therapy is singular in its dramatic effect on how occupational therapists perceive their professional roles and how they go about the day-to-day delivery of services in managed health care environments.

The participants in this study expressed three reactions to the change brought about by managed care: “pushing against it” by disagreeing, resisting, rebelling, and feeling unhappy, angry, and torn by the need to adapt to the new and experiencing the ache of letting go of the way it was before; “going with it” by taking charge of the situation, learning what is needed to succeed in the new order, and aligning attitudes, skills, and behavior with corporate medicine; and “making the best of it” by focusing on the opportunities that are inevitably inherent in change. We can draw some parallels between the challenge for occupational adaptation (Schkade & Schultz, 1992) that our patients experience when faced with a major change in their health status and the need for therapists’ occupational adaptation in response to the pervasive changes in their professional practice brought about by managed health care. Participant adaptation to change is expressed most dramatically in the “pushing against it” theme, as they wrestled with finding new meaning and purpose in their work (Fisher, 1998; Nelson, 1997) and struggled to restore their identity and sense of coherence (Christiansen, 1999) as professionals. With reformed health care came new measures of efficiency, effectiveness, and satisfaction; a new culture with new occupational forms (Kielhofner & Barrett, 1998); and changes in roles and purpose that were juxtaposed against the occupational form of occupational therapy practice in the past. Assuming that meaning is derived in the context of occupational form through one’s own experiences (Kielhofner & Barrett, 1998), part of the struggle the participants experienced in the new health care environment may reflect an attempt to find meaning in new practice forms.

The “getting on with it” businesslike perspective echoed our professional leaders’ advice to focus more on the economic value of occupational therapy (Evert, 1993; Foto, 1996, 1998a). Participants adjusted their own occupational performance in pace and efficiency, making professional role and practice changes in assessment, intervention, and documentation (Abreu, 1996; Baum & Law, 1997; Nelson, 1997). These adjustments were made in the context of new occupational forms—the rules, expectations, and culture of managed health care.

In “making the best of it,” participants appeared to be taking responsibility for developing new professional competencies needed to respond to changing practice demands (Hinojosa & Blount, 1998) and responding to the opportunities that accompany change (Foto, 1998b; Jacobs, 1998). In making these adaptations, the sustaining strengths of occupational therapy surfaced in the participants’ flexibility, their focus on function, and their concern for the welfare of their patients. Although interview conversations were predominated by the challenges of managed health care, each participant also expressed positive aspects of change. Just as it does in the entire health care system, managed care forces those of us in occupational therapy to examine carefully what we are doing for those we serve, makes us accountable for our practice, and challenges us to define our contributions. Although focused on occupational therapy, participants also espoused a broad perspective of the health care system and viewed the changes in occupational therapy in the context of reform needed to serve our patients and to retain our place in the health care marketplace in the next millennium.

In suggesting educational outcomes for practice in managed health care, participants profiled future therapists as needing to be able to render services quickly and efficiently, to be well-grounded in the role of occupational therapy in health care, to have business know-how, to be excellent communicators, and to be able to use specific skills as well as to operate from a broad-based perspective. Ethical issues for occupational therapists in managed care centered on humanistic versus monetary values.

In this study, I brushed across the spectrum of changes resulting from reformed health care; future studies may address other specific issues such as threats to professional ethics and changes in therapy procedures, including assessment strategies and family consultation. The results of this study summarized the experiences of 25 therapists expressed in a one-time interview; future studies could involve several interviews over time to address change process phenomena (Clark, 1993). Further study of how we as therapists adapt to change can assist us in examining some of our assumptions about occupational form, occupational performance, occupational adaptation, and meaning that could help us understand the change processes we aspire to for patients.

Lest we become complacent about our adjustment to managed health care, we may want to contemplate the intransigence of change ushered in by managed care. The shift to managed health care was not a single event in time that required a period of adjustment and then implementation according to a new order. On the contrary, health care is in a “period of permanent change, driven by competition, demographics, and above all, technology” (Lohman, 1998, p. 15). As occupational therapists, we will need to look to our traditional flexibility, creativity, and concern about humans as occupational beings combined with political and business savvy to continue to adapt to changes in managed health care.
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